INSTRUCTIONS FOR COMPLETING INITIAL APPLICATIONS AND CHANGE OF OWNERSHIPS FOR NURSING FACILITIES

PART I

Reason: Place an "x" in the appropriate box to indicate the reason for the application.

Line A – Identification: Full legal name, physical address, city, zip code, county, telephone number fax number and Federal tax ID number.

Line B – Administrator: Name of the individual who is charged with general administration of the nursing facility. *(If the facility has an assisted living or residential health care facility licensed along with the nursing facility and has hired an "operator", list the name of the operator).*

Line C – Licensed Beds: Select the category(ies) along with the number of beds. Indicate total beds.

Line D – Surety Bond/Professional Liability Insurance Company Information: Name of the insurance companies and the amount of the surety bond and liability coverage.

Line E – Owner of Building: Name and address of the person, organization or business entity that owns the building as it appears on the warranty deed. *(A copy of the warranty deed and purchase agreement will need to be submitted).* Part II of the application must be completed.

Line F – Lessee or Contract Purchase: Name of person or business entity who receives the use and possession of lease property in exchange for a payment of funds. Also known as tenant and has a lease agreement with the landlord. *(A copy of a signed lease agreement will need to be submitted).* Part II of the application must be completed.

Line G – Sublessee: Name of the person or business entity who receives the use and possession of the lease property in exchange for payment of funds. Also known as tenant and has a sublessee agreement with the lessee. *(A copy of a signed sublease agreement will need to be submitted).* Part II of the application must be completed.

Line H – Management Firm: Name of the person or business entity that has a management agreement to operate the facility. *(A copy of a signed management agreement will need to be submitted).* Part II of the application must be completed.

Item I – Other Entities: Name of any other business entity involved in operating or in managing the nursing facility.

PART II *(Each licensee appearing on Part I, Lines E, F, G, H or I must complete and sign Part II)*

Line A – Identification*:* Full legal name, address, city and zip code.

Line B – Business Entity: Name of organization or entity established as a separate existence for the purpose of taxes *(corporations, limited liability companies, sole proprietorships, etc.).*

Line C – Type of Entity: Place an "x" in the appropriate box to indicate type of entity.

Line D – Resident Agent: -- Name and address of the resident agent. *(Business entities are required to register with the Secretary of State and designate the resident agent)*. Complete the boxes listed below with the business entity listed on Line B.

ADDITIONAL DOCUMENTS TO SUBMIT:

1. A copy of the warranty deed to the building. *(A signed sale agreement for CHOWS).*
2. A signed lease, sublease and/or management agreements.
3. A financial statement projecting the first month's operating income and expense for the facility.
4. A balance sheet showing a minimum of one month's operating expense in cash and/or owner's equity. *(This is for the business entity, i.e., corporation, limited liability companies, sole proprietorship, etc.).*
5. Resumes of applicant's executives from corporation or business entity involved with operating or supervising the operation of the facility.
6. Submit a complete list of facilities any of the applicants own or are operating in other states.
7. Submit a copy of the Resident Fund Surety Bond and certificate of Professional Liability Insurance.

MEDICARE/MEDICAID ENROLLMENT INFORMATION:

The following information concerns the requirements and procedures required for a nursing facility to be approved to participate in the Medicare program.

1. Nursing facilities must be certified for Medicaid prior to receiving approval to participate in the Medicare program.

    - All initial Medicare certification surveys have been determined by The Centers for Medicare and Medicaid Services (CMS) to be ***low priority***.
    - All initial certification surveys will be Medicaid-only.
        - For Medicaid certification contact Rhonda Boose at (785) 368-6685 or by email at rhonda.boose@kdads.ks.gov.
    - Facilities may seek Medicare certification after they are Medicaid certified.

2. As part of the application package applicants are required to complete a CMS-855A, "Medicare Enrollment Application" booklet.

3 To become certified as a Medicare provider a facility must first be surveyed. Our surveyors will inspect your facility, interview you and members of your staff, review documents and undertake other procedures necessary to evaluate the extent to which your facility meets the Conditions of Participation. If your facility has significant deficiencies in any of the conditions, you will be informed and given an opportunity to correct them. Following the survey, we will recommend to CMS whether your facility should participate.

    - Your facility cannot be certified or scheduled for a survey before the CMS-855A booklet has been approved by your MAC.

4. For existing facilities, a determination will be made whether a full survey will be necessary.

5. For newly constructed facilities, a licensure survey must be completed and a license issued prior to completing a certification survey for Medicaid. Following licensure, at least 1 resident must be admitted prior to the initial Medicaid certification survey. Upon admittance of the first resident, you are to notify your respective Regional Manager or this office to schedule an initial Medicaid certification survey.

6. Facilities denied approval to participate in the Medicare program will be sent notification indicating the reasons for the denial plus information regarding their right to appeal the decision.

7. Once CMS has determined that all requirements are met, the Health Insurance Benefits Agreement (CMS-1561) will be countersigned. One copy will be returned to you along with notification indicating your facility has been approved.

APPLICATION FORMS:

The following forms are required to participate in the Medicare program.

# OF COPIES	FORM NUMBER AND NAME	WEBSITE:
2	CMS-671 "*Skilled Nursing Facility Application for Medicare and Medicaid*"	http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS671.pdf
2	CMS-1561 *"Health Insurance Benefits Agreement"*	http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1561.pdf
2	HHS-690 *"Assurance of Compliance"*	http://www.hhs.gov/forms/HHS690.pdf
1	*"Office of Civil Rights"* packet	http://www.hhs.gov/ocr/civilrights/clearance/ocr_mctap.pdf
1	*CMS-855A "*Medicare Enrollment Application"*	*www.cms.gov/Medicare/CMS-Forms/CMS-Forms/.../cms855a.pdf*.

Hardcopies of these forms are available by contacting Tina Lewis at (785) 296-1260 or by email at tina.lewis@kdads.ks.gov.

Send all completed forms plus a cover letter indicating the effective date of Medicare participation to: Tina Lewis, KDADS, 612 S. Kansas Ave, Topeka, Kansas 66603.

* *CMS-855A, "Medicare Enrollment Application" booklet:*

- You will need to contact your MAC for a copy of the CMS-855A booklet or go to the website listed above to download a copy. KDADS does not provide copies of these booklets.
- Contact your MAC if you have any questions regarding completion of this CMS-855A booklet.
- *Do not send your completed CMS-855A booklet to KDADS. Send it to your MAC.*